

# forum

N C M E D I C A L B O A R D

Using IT to Improve Patient Care  
and Communication — Page 3

## President's Message

### The Medical Supervisor-Trainee Relationship and the Wisdom of Dr Osler



Stephen M. Herring, MD

Following several months of discussion on the subject, the North Carolina Medical Board adopted a position statement emphasizing the significance of the relationship between teacher and student in medical education at all levels and the importance of that relationship being understood and respected. That position statement, The Medical Supervisor-Trainee Relationship, appears at the end of this article. Though brief, it carries a

vital message for all those engaged in the educational process.

As the Board considered this position statement, I couldn't help but pick up the *Quotable Osler* to review some appropriate words of Dr William Osler (1849-1910), one of the finest medical educators of any era and a founder of The Johns Hopkins University School of Medicine. His *Principles and Practice of Medicine* (1892) was the leading medical text of its time and is still published today. His comments pre-date antibiotics, the transistor, space flight, and the desktop computer. They remind us of the timeless nature of wisdom, and the great debt our profession owes to those who choose careers as medical educators. They are worth reading and rereading—particularly the last.

"That greatest of ignorance—the ignorance which is the conceit that a man knows what he does not know."

"The greater the ignorance the greater the dogmatism."

"One special advantage of the skeptical attitude of mind is that a man is never vexed to find that after all he has been in the wrong."

"Common-sense nerve fibers are seldom medullated before forty—they

are never even seen with a microscope before twenty."

"Perhaps no sin so easily besets us as a sense of self-satisfied superiority to others."

"Keep a looking glass in your own heart, and the more carefully you scan your own frailties, the more tender you are for those of your fellow creatures."

"Silence is a powerful weapon."

"Beware of words—they are dangerous things. They change colour like the chameleon, and they return like a boomerang."

"Care more particularly for the individual patient than for the special features of the disease."

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

"Errors in judgment must occur in the practice of an art which consists largely of balancing probabilities."

"Medicine is a science of uncertainty and an art of probability."

"The practice of medicine is an art, based on science."

"What is your duty in the manner of telling a patient that he is probably the subject of an incurable disease? . . . One thing is certain; it is not for you to don the black cap, and, assuming the judicial function, take hope from any patient—hope that comes to all."

"Gentlemen, if you want a profession in which everything is certain you had better give up medicine."

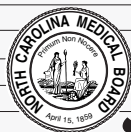
"You cannot afford to stand aloof from your professional colleagues in any place."

"A physician who treats himself has a fool for a patient."

"In no relationship is the physician more often derelict than in his duty

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*Primum Non Nocere*

# forum

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

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to himself."

"Common sense in matters medical is rare, and is usually in inverse ratio to the degree of education."

"Longevity is a vascular question."

"Humanity has but three great enemies: Fever, famine, and war; of these by far the greatest, by far the most terrible, is fever."

"Soap and water and common sense are the best disinfectants."

"The glutton digs his own grave with his teeth."

"Remember how much you do not know. Do not pour strange medicines into your patient."

"It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it."

"It goes without saying that no man can teach successfully who is not at the same time a student."

"Superfluity of lecturing causes ischial bursitis."

"Advice is sought to confirm a position already taken."

"I desire no other epitaph . . . than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work that I have been called upon to do."

Thank you Dr Osler and educators alike.

## New NCMB Position Statement: Medical Supervisor- Trainee Relationship

It is the position of the North Carolina Medical Board that the relationship between medical supervisors and their trainees in medical schools and other medical training programs is one of the most valuable aspects of medical education. We note, however, that this relationship involves inherent inequalities in status and power that, if abused, may adversely affect the educational experience and, ultimately, patient care. Abusive behavior in the medical supervisor-trainee relationship, whether physical or verbal, is a form of unprofessional conduct. However, criticism and/or negative feedback that is offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

(Adopted April 2004)

# Using Information Technology to Improve Patient Care and Communication: A Practical Guide—Part 1

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Ms Satinsky

Information technology may be able to help you improve the efficiency of four aspects of your practice: patient care and communication, financial management, clinical practice/operations, and professional growth. Patient care and communication is every physician's priority, so let's start there. Future articles

will cover the application of technology to professional growth and other topics.

Throughout North Carolina, practices of all sizes already use information technology for pre-registration, appointment reminders and requests, on-line bill payment, test reporting, patient education, on-line physician-patient communication, and the coupling of patient specific information with options for diagnosis and treatment. The practices that are most satisfied with these applications of technology to patient care and communication have carefully analyzed their work flow, identified specific problems that they want to correct, looked at technological options, selected solutions to meet their needs, and begun to document a positive impact on patient satisfaction, operational efficiency, and cost.

For many reasons, however, most practices don't use technology for patient care and communication. Some practices are opposed in principle to any mechanism that changes their existing methods of care and communication. Other practices have preconceived notions about prohibitive costs, lack of time to investigate available options, and vendor inability to customize available tools to meet their unique needs.

In Part 1 of this article, I hope to present a practical guide to help you understand ways in which information technology may be able to help you improve patient care and communication in your practice. I want to direct my comments particularly to those of you who are in smaller and solo practices and who may, for one reason or another, question the value of technology for your patients and for yourselves. I describe common applications and suggest steps you can take to determine if information technology can help you.

In Part 2 of this article, which will appear in the next issue of the *Forum*, I will present several short profiles of medical practices throughout the state that now use technology to impact patient care and communica-

tion. Read these descriptions to learn what your colleagues are doing, what challenges they face, how they make their decisions, and how they monitor their success in meeting their goals. And, since patients come first, I will also include comments from several patients of physicians who have adopted the use of technology to improve patient care and communication.

## The Value of Patient-Centered Care and Communication

Most discussions of information technology as a tool to improve patient care and communication focus on the technology part of the phrase. Information technology triggers a gut reaction related to the bells and whistles of hardware and software. It's easy to ignore the underlying premise.

Dr Larry Weed, a well-respected medical educator whose approach to patient-centered medicine has influenced thousands of physicians, offers a relevant perspective. "From both clinical and economic perspectives, patients and their families are the most neglected and the most important actors in the healthcare system." (Weed and Weed, 1994, and Weed, 1997). Dr Weed suggests that "properly designed information tools" can enable patients to "engage in an informed 'conversation' with providers and assume a greater role in their own care than in the past." Following Dr Weed's reasoning, physicians should care about patient communication not only because patients are better informed and more demanding than they used to be, but because active patient involvement in the delivery of medical care produces better decision making.

*"Most practices don't use technology for patient care and communication"*

## Common Applications of Technology to Patient Care and Communication

Let's explore ways in which information technology can enhance patient care and communication by looking at some of the common applications: pre-registration, appointment reminders and requests, test reporting, patient education, on-line physician-patient communication, and coupling patient information with diagnosis and treatment options.

### (1) Pre-registration

Most medical practices gather information about patients both at the point of check in and again when the patient goes to the examination room. Here's a

common scenario. Patients check in at the front desk and fill out a paper form that includes a review of systems, a history of present illness, and insurance coverage. They then move to an examination room, where a nurse or other clinical assistant takes vital signs and asks questions about presenting symptoms. The physician then talks with patients, does appropriate examinations, and if no further tests or services are needed, suggests appropriate courses of treatment. Depending on the office system, when the physician and patient interact directly, the physician may or may not have the information that has thus far been collected by the front office staff and by the nurse or clinical assistant.

With computerized, on-line pre-registration, your patients can have a very different experience. They use a secure line to input information into your practice's system from a home terminal or from a terminal or other device that is located in your office. They have time to review and check what they have entered. Elderly patients can ask family members to verify the accuracy of their entries.

By the time your patients reach the examination room, you already have their background and insurance information. You request additional information as needed. You enhance interactions with your patients by focusing on possible causes and treatment options. From your patients' perspective, satisfaction improves because you have more time to talk about the information that has already been collected. The practice saves the costs of dictation and transcription. You and your colleagues reduce the length of time that you spend with each patient without sacrificing quality. Because your staff validates insurance information prior to the visit, your practice can reduce the volume of claims denied because of incorrect payer data.

### ***(2) Appointment Reminders and Requests***

Many practices give patients the option of receiving automatic telephone reminders of appointments instead of personal reminder calls from staff. If the practice already has a computerized scheduling system, the automated reminder system can be linked directly to it. Using either a computerized telephone dialing and message system or an e-mail reminder, the system alerts patients to upcoming appointments and tells the practice which patients have not been contacted. Patients receive their reminders on a timely basis, and the practice can reduce the number of no-shows.

Another automated appointment feature allows patients to request appointments. Patients call in or use the practice Web site to request an appointment for a particular time and date, and the practice responds. Patient satisfaction increases because calls about appointments are not mixed in with requests for medical advice, prescription refills, and urgent care. The practice retains its ability to control the schedule.

### ***(3) On-line Bill Payment***

On-line bill payment with a credit card can improve both collections and patient communication. Although the co-payment feature of managed care has sensitized medical practices to the importance of collection at the time of services, not all patients pay when asked. As you know, many patients who have outstanding balances don't return for needed care because they don't want to experience the embarrassment of again being asked to pay their outstanding balances. On-line bill payment gives your patients a convenient alternative.

### ***(4) Test Reporting***

Automated test reporting is not suitable for all practices. If a practice has a well-organized and effective triage system that efficiently handles the reporting of test results, it may not want to consider this particular application of technology to patient care and communication.

In practices that are comfortable with automated test reporting, test results are returned to the physician so he/she can add an interpretation to the raw scores. For example, following an annual physical, you might request cholesterol and colorectal screenings. If the results are normal, your interpretation might be: "Your results on both tests look good. Keep up the good work and please use the practice's automated appointment system to make an appointment to return for your annual checkup next year." To get the test results, the patient either calls an 800 telephone number or accesses the practice Web site to enter a secure pass code. Patients like the automated mechanism because they can request results at their convenience. From a practice perspective, the test-reporting feature can reduce call volume and alert the practice when a patient does not receive results.

### ***(5) Patient Education***

Several technology applications can improve patient education. If your practice has a comprehensive and easy-to-navigate Web site, patients can use it to request information at any time of day or night. They no longer have to call the practice during business hours to get general information on services provided, physicians in each specialty, office location and directions, and flu shots. You can use your Web site to provide even more information to your patients by listing and responding to frequently asked questions, by writing and/or posting short articles on current topics of interest, and by directing patients to reliable sources of medical information.

You can also use technology to enhance patient education while your patients are in your office. One physician interviewed for this article engages his patients in Web searches during their office visits. In his opinion and mine, he's simultaneously accom-

*"Several technology applications can improve patient education"*



plishing two goals, both of which enhance the care that he provides. He's gathering as much current information as he can so he can make the best possible diagnoses and recommendations. He's also telling his patients that he believes in reliable on-line sources of medical information. By demonstrating the use of specific on-line databases in which he has confidence, he's guiding his patients in their own use of the Internet.

#### **(6) On-line Care**

A recent poll of physicians conducted by The Boston Consulting Group (BCG) and Harris Interactive (*Physician Profiling and Behavior Change*, 2002) documents patients' desire to communicate with their physicians on line. According to the physicians who responded to the poll, almost 90 percent of patients want to communicate with their physicians on line, and more than one-third indicate a willingness to pay for advice. More than half indicate that availability of on-line communication would impact their choice of physicians.

Physicians who are comfortable with on-line care and communication can provide different levels of information. For example, you can direct patients with general questions to educational material on your own Web site or guide them to the Web sites of reliable organizations. Your practice can also participate in one of the many on-line medical advice sites.

Another application of on-line care is prescription refills. With prior patient consent, the system stores patients' prescription histories, possible drug interactions, insurance coverage, and formularies. You can use the Internet to fax prescriptions directly to pharmacies. If you want to charge non-Medicare patients for the service, you can do so. A potential benefit to patients is reduced waiting time for the prescription. Your practice may also save staff time and reduce its operating costs (Ennis and Maus, 2001).

Going one step further, you can respond to patient-specific questions on line, reserving the right to ask the patient to come to the office for a visit. Depending on your philosophy of billing for on-line care and rules for Medicare patients, you can activate a mechanism that lets you charge for services rendered, provided that guidelines are established in advance and that your patient signs a written waiver allowing you to bill.

With all of these e-mail applications, "the key to successfully integrating e-mail communications into medical practices is to follow carefully thought out guidelines (Blumenfeld, 2002). Make sure you establish rules in advance. The American Medical Association offers guidelines for e-mailing that can help you define parameters.

The provision of patient-specific on-line advice is not attractive to all physicians. Many do not distinguish between secure on-line advice systems and tra-

ditional e-mail. The secure systems include firewalls, encryption, and other protections; e-mail does not have these features. Several of the physicians interviewed for this article mentioned potential difficulties in managing follow-up care and the increase in malpractice risk. HIPAA (Health Insurance Portability and Accountability Act) compliance is another barrier for some physicians; they would prefer not to implement on-line care at a time when new and complex regulations are going into place.

#### **(7) Coupling Patient Information with Diagnosis and Treatment Options**

Here's yet another way in which technology can improve patient care and communication. Let's go back to Dr Weed. He talks about the limitation of all physicians, no matter how well trained or experienced, to retrieve and organize relevant information and apply logic and clinical judgment to arrive at a decision (Weed and Weed, 1994 and Weed, 1997). With the exception of new patient visits, physicians spend 10-15 minutes, sometimes less, with most patients. If technology can be used to couple each patient's history, including subjective information provided directly by the patient, with all of the possible causes and treatment options, the physician is in a position to make the very best possible recommendation for each unique patient.

A pediatric clinic in the Triangle already uses technology in just the way that Dr Weed suggests. The clinic is a part of a not-for-profit organization devoted to helping children and adolescents whose learning differences present difficulties in school. A multidisciplinary team of pediatricians, psychologists, and learning specialists provides assessments and recommends interventions. The homegrown technology that supports the clinicians combines information provided by families, teachers, and the child with observations and other results from a daylong assessment. The clinicians are specially trained to use the software to create an individualized profile of each child. That profile is matched against 1,000 possible interventions. The interventions are categorized, reviewed, and improved on an continuing basis. With the aid of this technology, every family receives a description of clinical findings and recommended interventions that is customized to the individual child.

### **Getting Started**

If these descriptions of ways in which technology can improve patient care and communication in medical practices interest you and you want to learn more, here are six suggestions for starting your investigation: (1) understand your problems and define your goals; (2) identify an information technology team; (3) seek facts from various sources; (4) select one or more vendors; (5) implement the new system; and (6) measure results.

*"Understand  
your problems  
and define  
your goals"*

### *(1) Understand Your Problems and Goals*

The first step is crucial, and you don't have to leave your office to do it. Information technology tools help you solve problems. They don't identify your problems, determine goals for your practice, or tell you what values are important to you and your colleagues.

As I researched this article, I posed the same question to physicians in many different practice settings: "How do you use information technology to help you with patient care and communication?" Most respondents told me about their practice management systems, electronic medical record systems, and Web-based systems. Very few told me what those systems do for them and their patients.

Start by thoroughly understanding your existing processes for patient care and communication. Analyze your workflow and collect hard data to help you understand the depth and impact of your problems. Review the results of your patient satisfaction surveys. Your patients are your focus, and they will tell you what they like and don't like. Then think about the direction in which you want to go. If you understand your current status and desired goals, you are ready to take the next step.

### *(2) Establish an Information Technology Team*

More than one physician interviewed for this article learned the hard way that no matter how much you believe in the benefits of technology, IT decision making is equally as challenging as organic chemistry. No matter how small or large your practice may be, it's best to take a team approach to IT planning and implementation. You need to choose the right group of people to help you assess your practice, identify problems, determine and review options, and make good decisions.

If you're a solo practitioner without an IT expert on your staff, consider engaging outside help. If you belong to an IPA, PHO, or other similar organization, see how these organizations can help you evaluate options and purchase hardware and software. Keep in mind, however, that every practice is different. When a large umbrella organization is involved in the investigation and selection process, you need to make sure you get what you need, not just what is best for the majority of medical practices in the group.

If your practice is larger, think carefully about the IT team that you form. Physician involvement is essential, since physicians will be the primary users. It is helpful to involve a physician who is interested in technology, is willing to take the time necessary to explore options, and has credibility with his/her physician colleagues. If your practice has multiple specialties, be sure they are appropriately represented, but don't form a working group that is too large to function. Include on your team your practice administrator, information technology manager, and clinical and administrative staff so you can begin to cultivate

involvement and cooperation by everyone. Be realistic about time commitments.

### *(3) Seek Facts*

Every medical practice is unique, and you are ultimately seeking solutions that meet your practice's needs. Nonetheless, as you get started, you can obtain comprehensive general information from a variety of reliable resources. Use the Internet to find relevant articles. Check with your state and local medical and specialty societies to learn what others in your region are doing. When you attend national meetings in your specialty, talk with exhibitors and with colleagues in other states.

Keep an open mind about the likelihood of finding answers that work for your practice and that fit within your budgetary constraints. Technological advances now allow small practices to find practical and affordable solutions (California HealthCare Foundation, 2002). Some of these advances are:

- Improvements in Web-based technology and Internet access that offer remote hosting and no longer require expensive mainframes and PCs. Practices that use Application Service Providers (ASPs) pay a fixed monthly rate and can avoid paying high up-front purchase costs.
- Availability of mobile computer devices that accompany users as they move from place to place.
- Modular product design that allows practices to make incremental enhancements in their technology.
- Wireless computer linking that avoids bulky cables.
- Advances in equipment design that include wireless laptop computers and handheld devices.
- Increased compatibility among applications created by changes in industry standards.

### *(4) Selecting a Vendor*

You have many choices of vendors. As you gather information, learn to distinguish sales and marketing hype from actual capability and track record. Talk both with vendors that offer single applications as well as with vendors that can add functions to their basic packages. For example, many PMS and EMR systems now have the capability to activate additional functions that relate to patient care and communication. The California HealthCare Foundation Report referenced above includes a comprehensive list of applications and vendors categorized under three main headings: financial, clinical, and patient-focused.

Lay out your specifications in a formal Request for Proposal (RFP) so you can ask vendors to respond to your specific needs and ensure that all vendors are responding to the same set of questions. Make sure you ask about impact on patient care and communication, physicians' productivity, cost, ease of learning, and interface with your current practice management system. Check on 24-hour availability of technical

*"Technological advances now allow small practices to find practical and affordable solutions"*

support so you can get help when you need it and avoid having your operations come to a total standstill.

Make site visits to vendors and to their other clients so you can better understand the experiences of other users. The vendors will want to accompany you on some of these visits. Take time to make additional visits on your own. During these less formal site visits, ask if you can shadow a physician who is using the technology so you can observe firsthand what happens during a physician-patient interaction. Request permission to talk directly with patients. It's important for you to get their opinions on the impact of technology on their care and on physician-patient communication.

Ask many questions about vendor training for you and your staff. You want to make sure the trainer assigned to you has the breadth of knowledge to answer a variety of questions, and that the trainer won't be assigned to another client before your needs are met.

Check vendor financial viability very carefully. Some companies won't be in business long enough to let the ink dry on your contract. Other newcomers are experiencing growing pains of their own and may have difficulty providing you with the consistent good service you want.

Finally, make sure your contract includes all the items on which you and the vendor have agreed. Read the fine print, and don't rush to implement your new systems before the details are in place.

### **(5) Implement the System**

Once you have selected a vendor, plan the implementation down to the smallest detail. List each step to be taken, expected time, and responsibility. Expect disruption if you are converting from an existing system to a new one, and plan accordingly. Pay attention to the human side of implementation, and remember that you are dealing with physicians and staff with varying degrees of interest and ability in new technologies. Effective training programs may require individualized attention in addition to group sessions.

### **(6) Measure Results**

Measuring the impact of your technological change is imperative. If you identified specific and clear goals for your project, you'll want to match progress against them. You're not just looking at technology, but whether or not the technology you adopted helps you solve problems in patient care and communication without having unanticipated negative side effects like lowering physician productivity and ability to generate revenue (Moore and Woodcock, 2002).

## **Conclusion**

Information technology has great potential for improving patient care and communication in your

practice. If you know what problems you want to address, involve the right people in your decision making, and are conscientious in vendor selection, implementation, and measurement of results, you may be able to improve patient satisfaction and simultaneously realize a positive impact on cost and operational efficiency.

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*“Measuring  
the impact  
of your  
technological  
change is  
imperative”*



Hospital Publishing, 1995). She is also author of an article titled *The Advanced Practice Nurse in a Managed Care Environment*, which appears in the book *Advanced Practice Nursing: Changing Roles and Clinical Applications*, edited by J.V. Hickey, et al (Lippincott, 1996, and Lippincott, 2000). The *Forum* has previously published two articles by Ms Satinsky: *Managing the Implementation of HIPAA and the Privacy Rule*, in #4, 2002; *How to Determine If Your Practice Could Use a*

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## SUGGESTED RESOURCES

### Organizations That Focus on IT

American Medical Informatics Association (AMIA) publishes a monthly informatics journal ([www.amia.org](http://www.amia.org)).

Health Information and Management Systems Society (HIMSS) publishes a quarterly journal (*Journal of Healthcare Information Management*) and sponsors an annual conference with a large vendor exhibition ([www.himss.org](http://www.himss.org)).

### Magazines and Trade Journals

*Healthcare Informatics* is a monthly journal that frequently features software comparison guides ([www.healthcare-informatics.com](http://www.healthcare-informatics.com)).

*Health Data Management* is a monthly trade magazine that publishes an end-of-year resource guide on information technology vendors ([www.healthdatamanagement.com](http://www.healthdatamanagement.com)).

*M.D. Computing* is a monthly publication endorsed by AMIA. It includes an annual Directory of Medical Hardware and Software Companies ([www.mdcomputing.com](http://www.mdcomputing.com)).

### Physician Practice Management Organizations

Medical Group Management Association (MGMA), the professional organization for physician practice leaders, offers reference books and a research service. It holds an annual fall conference with a vendor exhibition focused on physician practices ([www.mgma.com](http://www.mgma.com)).

PhysiciansPractice.com is a source for articles on IT for physician practices. It lists selected vendors by product type ([www.PhysicianPractice.com](http://www.PhysicianPractice.com)).

### Professional Organizations and Societies

American Academy of Family Physicians (AAFP) offers various resources, including a vendor survey, vendor requirements, FP Net (online computer information source) and Fam-Med *listserv* ([www/aafp.org](http://www/aafp.org)).

American Medical Association (AMA) offers various resources and publications ([www.ama-assn.org](http://www.ama-assn.org)).

American College of Physician Executives (ACPE) offers resources, publications, and seminars ([www.acpe.org](http://www.acpe.org)).

## Now—File Complaints with the Board by E-Mail

The North Carolina Medical Board maintains a Web site we hope the public finds easy to use. We also hope it serves as a useful and informative tool for individuals accessing information, filing a complaint, and generally learning about the Board and its work. In an effort to enhance the site's usefulness, the Board's Complaint Department has recently developed and introduced a new, faster, and more efficient option for submitting a complaint to the Department for review—direct e-mail.

The Complaints section of the Web site can be accessed by clicking on "Complaints" on the site's home page menu. The Complaints section offers a link providing information about the overall complaint process and a link presenting the two options for filing a complaint with the Board.

Option one for filing a complaint, and the Board's preferred method, is to submit the complaint directly to the Board by e-mail. When using this approach, it is essential to include the complainant's name, address, and daytime telephone number. If the individual filing the complaint is the patient, it is necessary to also include their date of birth. If the complainant is not

the patient, the patient's name and date of birth must also be provided. The full name and address of the practitioner about whom the complaint is being filed must also be included. Filing by e-mail, though preferred, is not recommended for those filing a complaint that must include the submission of various attachments, such as letters, records, or other documents.

Option two is to file a complaint form by mail, sending it to the Complaint Department at the Board's address. The form is offered on the Web site in two formats, one compatible with Adobe Acrobat Reader (PDF) and one with Microsoft Word. Individuals selecting this option may download the complaint form, complete it, and mail it with any necessary attachments.

Please visit the Board's Web site at [www.ncmed-board.org](http://www.ncmed-board.org) for more information. For specific questions regarding filing a complaint or about the process, please call the Complaint Department between the hours of 8:30 AM and 4:30 PM, at (919) 326-1100, ext 236 or 261.



# Public Schools and Pregnant and Parenting Adolescents: A Legal Guide

Anne Dellinger, JD

Professor, Public Law and Government, Institute of Government  
The University of North Carolina Chapel Hill



Professor Dellinger

The Institute of Government at the University of North Carolina Chapel Hill publishes legal guides for North Carolina's pregnant and parenting minors and those who care for them, and an article about each guide has appeared in the *Forum*. The first guide, on health care, was issued in 2001, and the second, describing social services available for these young people, was published the following year. The current article describes the third guide, *Public Schools and Pregnant and Parenting Adolescents*, which focuses on education for pregnant and parenting teens and pre-teens and will be available in May 2004. The last guide, for adolescents and including a special chapter for their parents, will follow within a year and will be printed in Spanish as well as English.

Each guide has been sent to nearly 10,000 professionals across the state. A number of grants, chiefly from the Z. Smith Reynolds Foundation, and underwriting from the Institute make it possible to distribute the books without charge. In addition, anyone can read or print the texts and accompanying resource lists from <http://www.adolescentpregnancy.unc.edu>. In its first two years, the Web site has recorded more than 30,000 first-time visitors.

Arlene Davis, formerly a nurse, now a lawyer and faculty member in UNC Chapel Hill's Department of Social Medicine, and I direct the adolescent pregnancy project. Our goals for the project are that

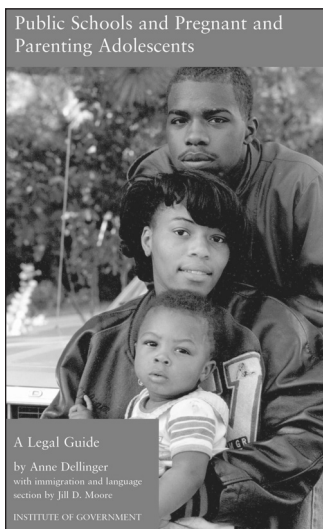
- minors understand their legal choices;
- they have access to health care, education, and social services while pregnant or parenting;
- adults recognize that teens are sometimes lawful decision makers;
- caregivers not overlook the possibility that abuse, neglect, or coercion may be implicated in minors' sexual relationships; and
- the role of adult advisors, either family members or professionals, is made easier.

## Historical Context

The third legal guide, *Public Schools and Pregnant*

*and Parenting Adolescents*, reviews the legal status of minors, explains education rights, and emphasizes the importance of continuing in school. To understand the barriers pregnant and parenting students often face, it is helpful to consider historical context. Until the last quarter of the twentieth century, U.S. schools routinely expelled pregnant and parenting youth. For example, forty years ago the deputy attorney general of North Carolina assured a local school board that it could legally refuse an unmarried girl re-entry after she gave birth. He went beyond legal advice, however, and counseled mercy. Because education is such an important benefit for the public and the individual, he recommended a compromise.

*"Until the last quarter of the twentieth century, U.S. schools routinely expelled pregnant and parenting youth"*



We suggest the person in question be allowed to return to school on probation and then the school administrators can observe the reaction and see how the matter works out. If it should turn out that because of this situation too many problems are created, then a permanent dismissal would be in order but a trial should be made of the pupil returning to school. It is simply too great a human responsibility to sit in judgment and condemn a person entirely or permanently from an educational standpoint for one misstep.

Several years later, the North Carolina General Assembly and Congress gave these students legal protection. The Assembly included pregnant students among the newly designated group, "children with special needs," although when the federal government passed similar legislation the next year, it did not. As a result, the states receive no federal funds to provide special education services to pregnant students. But Congress insured educational rights for pregnant and, to a lesser extent, parenting students in the ground-breaking law that forbids gender discrimination, Title IX of the Education Amendments of 1972.

Naturally, reality changes more slowly. Twenty years ago, the National Institute of Education reported that schools' handling of student pregnancy and parenthood is "constrained by a number of factors, including narrow (usually medical) definitions of the problem; opposition to sex education, contraception and abortion; disagreement about the appropriate school role;

*“Physicians can serve these patients by counseling them on contraception and pregnancy options”*

lack of expertise; and a lack of incentives to develop programs.” Only last year, Wendy Luttrell, now an education professor at Harvard, wrote of her work in North Carolina: “Title IX may have ended *de jure* discrimination but it did not end *de facto* discrimination against pregnant school girls.”

### Current Scene

Fortunately, some pregnant and parenting students meet school counselors, social workers, nurses, teachers, or administrators who expect them to continue their education and help to make it possible. Many such dedicated people work in North Carolina’s schools. A high school graduate, former foster child, and 19-year-old mother of three paid tribute to them. When asked whether she had considered dropping out, she exclaimed: “My teachers would never have let me do that! They’d have come and gotten me.”

But support for these young women is a scarce resource, as a school social worker explained.

My work is supposed to be with kids who’ve had court involvement, but I take the pregnant girls as extras because they’re not being served. We had 20 this year. One is 13 and too sick to stay in school any longer. She’s 13- or 14-weeks pregnant and probably won’t be back in school till the baby’s born. A DSS report has been made about her. Our DSS takes any report of this kind these days because in the past they wouldn’t and things turned out badly.

School personnel, physicians and nurses I have interviewed related the following incidents, among others.

- One student, angry about another’s pregnancy, threatened her in phone calls and pushed her at school. When the pregnant girl’s parents, who had tapes of the calls, contacted the school, they were told that the school could do nothing but offer homebound instruction.
- Near the beginning of a student’s pregnancy, her doctor ordered bed rest. The principal told her mother that no teacher was or would be available for home instruction.
- Pregnant students could get optimal care at a hospital teen clinic in an adjoining county. But most refuse the opportunity because the school requires time used for medical appointments be made up and that would frequently extend the school day to 5:00 p.m.
- A girl who gave birth in early August asked to return September 1. Another, with a Thanksgiving due date, who wanted to breastfeed, asked to return after Christmas. Both requests were denied under a policy that no student receives semester credit if more than 10 days are missed.

By all accounts, the youngest girls’ position is par-

ticularly difficult. Several school employees mentioned that girls who become pregnant in middle school face greater discrimination and isolation than older girls. A nurse described middle-school administrators as “very uptight about what they refer to as the ‘p’ word.” An administrator noted that these girls are not well accepted by peers, which makes it hard for them to stay in school. A nurse supervisor in a large district observed that staff, fearing a bad influence on other students, is even uncomfortable about letting a new mother visit. A counselor pointed out how often the youngest mothers soon become pregnant again and that many programs for teen parents will not accept anyone with more than one child.

Even older teens and those who do well academically face discrimination. Occasionally, school personnel single a girl out as a disgraceful example. For example, half a dozen National Honor Society chapters in other states have been sued for barring or expelling pregnant or parenting girls on the basis of character. In North Carolina, a teen who was elected homecoming queen, then disqualified by school authorities, charged that her unmarried motherhood was the reason.

### Counseling by Physicians

Physicians can help their young patients who become pregnant and decide to parent by encouraging them to return to school as soon as practicable and stay until graduation. According to the Alan Guttmacher Institute:

[D]ropping out of school, not having a baby, is the key factor that sets adolescent mothers behind their peers. If a pregnant teenager does drop out, it is unlikely that she will return to school before her children are in school. Adolescent mothers who stay in school are almost as likely eventually to graduate (73%) as women who do not become mothers while in high school (77%). In contrast, only about 30% of women who drop out of high school either before or after their baby’s birth eventually graduates.

To maintain a girl’s school status, a physician should inform the school when she must be absent due to medical necessity. (For a condition likely to last more than four to six weeks, the student, with a physician’s certification, is entitled to homebound instruction.) On the other hand, a physician does not help a patient by providing an excuse for absences that are marginal or unnecessary. Although North Carolina lacks data on educational outcomes for these students, many school personnel think that steady attendance during pregnancy and returning soon after delivery is best academically and socially, ensuring that the girl remains connected to school.

Above all, physicians can serve these patients by counseling them on contraception and pregnancy

options. In North Carolina in 2002, 76.6 percent of new mothers under age 20 reported that their pregnancy was unintended—and the percentage was very likely higher for mothers under 18. Since 1995, when North Carolina adopted and required an abstinence-based curriculum, very few adolescents have heard complete information about reproductive health at school. Only 12 or so school districts supplement the curriculum required by statute. In these circumstances, information offered by physicians and other health providers can change lives.

## Nota Bene

### About the Legal Guide Series

*Health Care for Pregnant Adolescents: A Legal Guide*, the first title in this series, was published by the Institute of Government, University of North Carolina at Chapel Hill, in the fall of 2001 and was

introduced to the Board's licensees in *Forum #3*, 2001. The second title, *Social Services for Pregnant and Parenting Adolescents: A Legal Guide*, was published in 2002 and presented in *Forum #3*, 2002. *Public Schools and Pregnant and Parenting Adolescents: A Legal Guide*, discussed above, is the third volume in the series. The final volume in the series, for adolescents themselves, with a special chapter for their parents, will follow in the coming year and will appear in Spanish as well as English. It will be announced in the *Forum* when available.

Professor Dellinger has been a faculty member at the Institute of Government at UNC Chapel Hill since 1974. She was formerly counsel with Hogan & Hartson, Washington, DC, and is author of numerous publications on health and hospital law, including an article, *How We Die in North Carolina*, in *Forum #2*, 1999. Her articles on the first two titles in the Legal Guide series appeared in *Forum #3*, 2001, and *Forum #3*, 2002.

## The Caring Lens



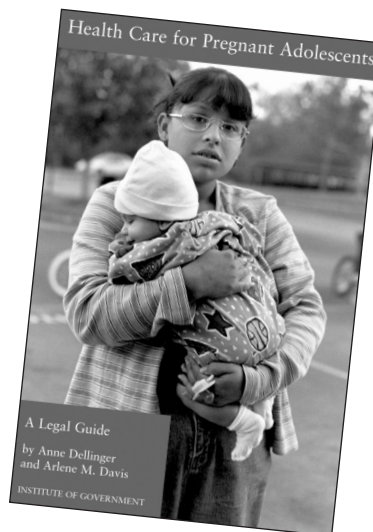
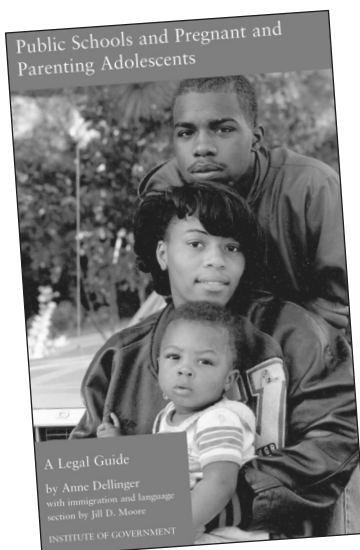
Dr. Moses

John Wills Moses, Jr., MD, is a primary care pediatrician and a documentary photographer based at Duke University. It is his distinctive work that appears on the covers of the Legal Guide series. A native of New York, he is a graduate of the Medical University of South Carolina and did his residency training at

Boston City Hospital and Yale-New Haven Hospital. He is board certified in pediatrics.

While maintaining a busy clinical practice, Dr

Moses teaches photography at Duke's Center for Documentary Studies. This spring semester, he is again teaching *Children and the Experience of Illness*, a course that incorporates teaching photography to children faced with chronic disease. His personal documentary projects have included a study of adolescent parents and innovative primary care clinicians. In addition to contributing images to the Legal Guide series, he has recently published his photographs in *The Youngest Parents* by Robert Coles, MD (Norton Press), and *Big Doctoring* by Fitzhugh Mullan, MD (University of California Press).





## NCMB Amends PA Rules

The North Carolina Medical Board has recently amended subchapter 32S, Physician Assistant Regulations, of the North Carolina Administrative Code. A copy of the rules is posted on the North Carolina Medical Board's Web site at [www.ncmedboard.org](http://www.ncmedboard.org), or you may access a copy through the Rules Division of the North Carolina Office of Administrative Hearing's Web site at <http://www.oah.state.nc.us>.

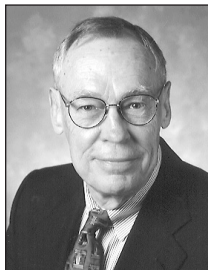
The amended rules include: 21 NCAC 32S .0106, Continuing Medical Education, which removes specifications for the continuing medical education of PAs who prescribe controlled substances; 21 NCAC

32S .0109, Prescriptive Authority, which no longer requires the supervising physician's co-signature on prescriptions written by the PA; and 21 NCAC 32S .0110, Supervision of Physician Assistants, removing the supervising physician's co-signature requirement of PA charts. [Note: Entries by a PA into patient charts of inpatients (hospitals, long term care institutions) must comply with the rules and regulations of the institution.]

The amendment of 21 NCAC 32S .0106 became effective April 1, 2004, and the amendments to both 21 NCAC 32S .0109 and 21 NCAC 32S .0110 became effective May 1, 2004.

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## George C. Barrett, MD, Receives FSMB Distinguished Service Award



Dr Barrett

George C. Barrett, MD, of Charlotte, a former member and president of the North Carolina Medical Board, was presented the Federation of State Medical Board's Distinguished Service Award on April 30 in Arlington, VA, at the Federation's 2004 Annual Meeting. The award recognizes his outstanding service to and leadership of the Federation and the field of medical licensure and discipline.

Dr Barrett served as president of the Federation in 2000-2001. His leadership helped stimulate signifi-

cant progress by state medical boards in the areas of license portability and continuing competency. In 2002, he chaired the Search Committee that selected James N. Thompson, MD, former dean of Wake Forest University School of Medicine, to be the new CEO of the Federation.

Additionally, Dr Barrett served the Federation in an array of other capacities, including service on the Special Committee on Strategic Planning and the Post-Licensure Assessment System/Assessment Center Program Committee. He is also a Federation representative to the Educational Commission for Foreign Medical Graduates.

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## Irregular Behavior in Sitting the USMLE Can Put a Medical Career in Jeopardy

On October 31, 2003, the United States Medical Licensing Examination Committee on Irregular Behavior made determinations in 27 instances that USMLE examinees had engaged in irregular behavior. The transcripts of those examinees were annotated to reflect those determinations. That means anyone receiving those examinees' USMLE transcripts in the future will be aware of the findings. In some cases, the examinees were also barred from USMLE for a period of time.

A determination of irregular behavior can put an examinee's medical career in jeopardy! Third parties, such as residency program directors and state licensing boards, receive annotated transcripts and make decisions that could adversely affect an examinee's future.

The conduct involved included bringing unautho-

rized material into the testing room (including cellular telephones, pagers, etc), falsification of information on USMLE documents (such as applications and score reports), making notes while in the testing room, and not adhering to proctor's instructions.

In 2003, seven examinees were found guilty of posting examination content in Internet chat rooms, and this led to sanctions as noted above. The posting of examination content in a public forum such as the Internet may provide unfair advantage to future test takers and is strictly prohibited.

Examinees are expected to be familiar with the *USMLE Bulletin of Information* and the rules of conduct. The USMLE program will use any means necessary and appropriate to protect the integrity of the examination program.

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# Nighttime Is the Right Time: Night Shift Workers at Pitt County Memorial Hospital Keep the Lights on After the Sun Goes Down

*Doug Boyd and Dena Marshall*



*Mr Boyd*

The night shift. Sometimes dark and quiet, sometimes wild and raucous, depending, some say, on the phase of the moon and whether it's a "pay-day Friday."

One thing is certain: night shift workers consider themselves just a little different from their daytime counterparts.

"Night nurses are a different breed. I'm a night person," said Family Birth Center nurse Frances Hamilton.

Clinician Bobby Jones put it a little more rhythmically: "We keep vampire hours and get none of the powers."

Several hundred people are needed to keep Pitt County Memorial Hospital and the

Brody School of Medicine at East Carolina University working through the night. Patients need 24-hour care. Research experiments sometimes conclude at midnight. A car crash can happen at any time.

"Night shift employees are a critical link and important to the system," said Tyree Walker, PCMH vice president of human resources. "These employees are highly skilled, work as a cohesive interdisciplinary team and meet the health care challenges every single night of the week."

Advantages, such as being off during the day and taking home shift-differential pay, attract people to the night shift. For others, it's just a way of life.

"It takes a quirky group of people to work nights," said nurse Nikki Dickinson. "You've got to be a little crazy."

## Darkness Settles, but Not Sarah Beth

One recent summer night at PCMH, 2-West—the pediatric floor—had 24 patients, most of them babies. Six-week-old Sarah Beth White was spending her first night in the hospital due to an infection. She drank from a bottle as she lay in her dad's arms.

"She woke up this morning with a temperature of 104," Sarah's mother, Winnie White, said at 9:30 p.m. "We think it's a urinary tract infection, but the doctor wanted us to stay a few days to rule out other infections."

The Whites were among many families spending

the night, some on 2-West and others elsewhere in the hospital.

"We encourage family members to stay overnight with younger children. They are allowed to bring items from home: blankets, stuffed toys. We try to follow their home routine as much as possible," said 2-West charge nurse Judy Holley.

Holley, a nurse for 35 years, hasn't always worked the night shift; she chose a day schedule when her children were young. She now prefers nights.

"There are fewer extra people on the floor," she said. "There is also a lot of teamwork on this floor that is excellent at night. It's just a whole different world."

With 35 babies in the Neonatal Intensive Care Unit and no windows, day and night meld amid a non-stop flurry of critically ill infants and hard-working clinicians. Karen Michaels, assistant nurse manager, has been working nights for nearly 20 years. She has no problem staying awake, but has found the shift takes some getting used to for some new nurses.

"As long as I stay busy, I'm fine," Michaels said. "We are pretty much doing stuff all night, but at three or four in the morning the new girls are usually tired, so we get them to walk the hallways to stay awake."

*"We keep vampire hours and get none of the powers"*



*Ms Marshall*



*Neonatal nurse Jennifer Callicut has worked nights for 12 years at PCMH.*

New nurses still have to rotate days and nights, so I suggest coffee, caffeine, Tylenol® and to keep on their routine as much as possible."

Not only do new nurses have to adjust to the night shift, but also the environment inside the NICU takes a toll on them, Michaels said.

"We have highly critical babies in this unit," she said. "We see a lot. The babies suffer, and the parents have a hard time stopping life support. We lost two babies today so it was a bad day, but we sit and talk about it. We tell the new nurses they did everything

they could, everything right.”

For nearly 12 years, Jennifer Callicut has worked the night shift in the NICU. She said the schedule allows her more family time.

“I worked days for a little while, but found nights were a lot easier on my family,” Callicut said. “I am able to see my children in the morning and also spend more time with them.”

Callicut admitted, however, the worst thing about working the night shift was jumping back into the routine after going on vacation. For Michaels, the downside is that the cafeteria is only open from 1 a.m. to 3 a.m.

Lorrie Pipkin, a nurse in the Family Birth Center, agreed with Callicut’s view on the night shift and chil-

a tertiary care center, patients come from all regions. There’s a constant flow of patients, so it’s rare if we are not busy.”

Robey said patients at night may come in for a variety of reasons ranging from violent crimes, to knife and gun incidents, to motor vehicle crashes involving alcohol.

According to Dr Ron Landry, assistant clinical professor of emergency medicine, the ED operates as it does during the day, prioritizing patients, taking care of the sickest ones first.

“It can get crazy at night,” Landry said. “You end up having to ‘put your finger in the dam’ so to speak, stabilizing your patients. It’s easier to get behind at night because of a decrease in staff and more odd patients coming in. It’s rare to have trouble staying awake, and it’s even more difficult just to sit down and feel tired.”

Dr Clarence Dunagan, a third-year emergency medicine resident, always works the night shift. During his first year, he rotated between days and nights, but said he prefers nights and has no trouble staying awake.

“I went to the Air Force Academy,” Dunagan said. “I can pretty much fall asleep on command.”

Meanwhile under a crescent moon, radiologic technologists Amy Ayers and Crystal Stalls sipped soft drinks during a break from duty in the Emergency Department. “It’s been a rough night,” Ayers said, citing a number of minor traumas in the ED. She said the night shift “suits my lifestyle. I’m not a morning person. I’d rather sleep all morning, then get up at noon.”

Usually after work, she goes to workout at ViQuest or to get breakfast with co-workers. “The lady at Bojangles knows me,” she said with a smile. On this particular morning, she had to attend a cardiopulmonary resuscitation class after work.

For PCMH police, the night can also be busy. Seven officers patrol the hospital, inside and out, rotating posts every three hours. Officer Houston Randolph, who’s been at the hospital for almost four years, said he receives numerous calls during his 12-hour shift.

“On a typical night, we can get calls for morgue releases, assault victims in the ED, and for families who may be emotional if a member has passed,” Randolph said. As part of his patrol at night, he also includes regular tours through the hospital and parking lots.

Vernon Lane, another PCMH patrol officer, described the patient calls: “They’re out of it. They’re having some kind of reaction to drugs. Patients can be violent.”

Inside the PCMH visitor lobby, Cynthia Ellis, lead visitor control receptionist, arrived at work dark and early at 4:30 a.m. Part of her job is to assist surgery patients and their families as they arrive for their pro-

*“I worked days for a little while, but found nights were a lot easier on my family”*



*Amy Ayers, left, and Crystal Stalls take a break from their jobs as X-ray technicians near the end of their night shift at PCMH.*

dren. After getting off work, she said, “you take them to school, you go to bed, then you get up in time to go pick them up, then you go to work.” If she worked days, she said, she would leave home before the children awoke and get home just in time for them to finish their homework and go to bed.

PCMH employees who work at night may be on a 3 to 11 p.m. shift, an 11 p.m. to 7 a.m. shift, or the long 7 p.m. to 7 a.m. shift. Some have variations of those hours.

One of those working from 7 p.m. to 7 a.m. was charge respiratory therapist Brian White. He guessed he and his co-workers walk five miles or more, day or night. He might walk from the Emergency Department to the Cardiac Intensive Care Unit almost 20 times in one night. He said the patient load for a respiratory therapist remains steady for day and night shifts. “It may fluctuate depending on new patients and patients who go home,” he said.

### **“It can get crazy”**

Nights in the Emergency Department can fluctuate, too. On this night, following a day with five traumas, it was busy.

“Right now, it’s packed in here like it is two in the afternoon,” said Dr Skip Robey, ECU associate clinical professor of emergency medicine. “Because this is



cedures. "Most of the time when I get here at 4:30, there are people sitting in the lobby waiting for me," she said.

On the Medical Intermediate Unit, hospitalist Anthony Smith was completing his shift. Hospitalists work seven days, then have seven days off. They alternate between a week on the day shift and a week on the night shift. As a fire alarm went off on the Medical Intensive Care unit, he talked about which shift he prefers.

"As a married guy, days," he said. "I don't see that much of (my wife) when I work nights." Dr Smith also pointed out that while the hospital is much less active at night, that doesn't mean patients get a lot of rest. "Patients for the large part are up because of noises and nurses checking on them. And the fire alarms."

With the shift drawing to a close, Family Birth Center nurse Debra Wright summed up her feelings of working at PCMH after dark: "It's awesome."

Reprinted with permission from the July/August 2003 number of *People*, the newsletter of University Health Systems of Eastern Carolina and the East Carolina University Division of Health Sciences. Photos by Cliff Hollis.

Doug Boyd is editor of *People*. Dena Marshall is a former

staff assistant of *People* and now serves as assistant in the NCMB's Department of Public Affairs and as assistant editor of the *Forum*.



PCMH police officer Freddie Bowen raises the flags in front of the hospital as the sun rises behind him.

*"It's easier to get behind at night because of a decrease in staff and more odd patients coming in"*

## USMLE Clinical Skills Examination to Debut in June 2004

After years of development and the investment of millions of dollars, the United States Medical Licensing Examination Step 2 Clinical Skills examination (Step 2-CS)—the first such testing of medical graduates in 40 years—will debut in Philadelphia in June.

The examination assesses whether an examinee can demonstrate the fundamental clinical skills essential to safe and effective patient care under supervision. It is a one-day test that mirrors a physician's typical workday in a clinic and other settings. Examinees will examine 11 or 12 "standardized patients"—people trained to portray real patients.

More than 3,000 students have registered for the examination since registration began in January. Following the opening of the Philadelphia examination center, additional cen-

ters will be opened in Atlanta in July, in Los Angeles in August, and in Chicago and Houston in September.

A wide-ranging effort to educate the profession about the new examination continues. The National Board of Medical Examiners, which co-sponsors the USMLE with the Federation of State Medical Boards, has invited the deans from all LCME-accredited medical schools to participate in "learning labs" to learn first hand about the examination. Deans from more than 85 schools are expected to participate. Additionally, the Federation and the NBME will bring a delegation from the American Medical Association to visit a testing center and discuss the examination.

*NewsLine*, Federation of State Medical Boards



## REVIEW

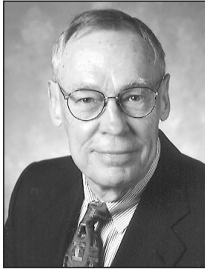


## Learning the Lessons That Will Make Us Uncomfortable

George C. Barrett, MD

Former President, NCMB

Former President, Federation of State Medical Boards



Dr Barrett

For 2,500 years, the Hippocratic oath has proscribed giving a deadly drug to a patient or making a suggestion to this effect. As we have developed both mechanical and chemical means of prolonging the labor of death, there has been an increasing concern regarding the role physicians should play, if any, in assisting in the suicide of patients who are terminally ill and who have felt that they can no longer endure their life.

In 1997, anticipating that physician-assisted suicide would become legal as it did in Oregon, the editors of this book, *Assisted Suicide: Finding Common Ground and Guidance for Real-World Implementation*, organized a project at the University of Pennsylvania Center for Bioethics, convening a national panel of experts on the subject of assisted suicide. The panel membership was multidisciplinary—with representatives from medicine, nursing, psychology, Hospice, patient advocacy, law, philosophy, the clergy, and bioethics. The panel was deliberately composed of individuals with diverse viewpoints on assisted suicide—some for, some against. The goal assigned this panel was not to argue the pros or cons but, rather, starting from the assumption that legalization was coming, to seek common ground in examining how to guide practices and determine safeguards that would keep assisted suicide voluntary, regulated, and an option of last resort.

They acknowledge that they avoided what might be considered the “real” issue, the issue of the morality of assisted suicide. They further acknowledge that it is an important question, but it is not the only question. That assisted suicide is going on does not make it right, but it does require some guidance for the practice. They decided morality was not the urgent question to be addressed.

The panel, which was named “The Assisted Suicide Consensus Panel of the Finding Common Ground Project,” debated many questions: What is assisted suicide? Is physician-assisted suicide different from refusal of treatment? Are there alternatives to assisted suicide? How useful are currently available guidelines for physician-assisted suicide? Who should have access to what? Does assisted suicide necessarily mean physician-assisted suicide? Can it be effectively and meaningfully regulated? How should physicians respond to requests for assisted suicide?

The book provides expanded versions of the consensus papers, with additional chapters developed by different members of the panel.

Following is the editors’ chapter-by-chapter summary of questions addressed, with my occasional comments for clarity.

### Chapter One

Some context on early implementation of the Oregon law is provided and the implications for end of life care in that state.

### Chapter Two

“Assisted Suicide and Refusal of Treatment: Valid Distinction or Distinction Without a Difference?” initiates a policy debate at the beginning with an examination of definitions and first principles. This chapter deals with the distinction between refusal of treatment and assisted suicide. It also cites the issue of causation to account for the distinction between withdrawing life sustaining treatment and assisted suicide. The panel clearly distinguishes between assisted suicide and refusal of treatment.

### Chapter Three

“The Role of Guidelines in the Practice of Physician-Assisted Suicide” asks several key questions: “what goals do guidelines serve, who should formulate them, what barriers are there to the creation and implementation of guidelines, and, fundamentally, is dying a process that is amenable to direction under guidelines by physicians?” The panel notes a concern that the debate about guidelines to regulate the practice of physician-assisted suicide has been shaped more by overall attitudes about the desirability or undesirability of legalization than by any particular set of guidelines and their merit.

### Chapter Four

The question: “Ought Assisted Suicide Be Only Physician-Assisted?” The assumption has been inherent in many discussions that assistance with suicide generally means physician-assisted suicide. This chapter seeks to define both the necessity and limits of the physician’s role in assisted suicide. It concludes that assisted suicide requires physician involvement, but physicians’ limited competence in performing the full range of tasks is too narrow a construct. This leaves open the possibility of other professionals expanding their authority in this area.

### Chapter Five

In many respects, this chapter poses a seminal question. The authors examine the assumption that, if there are times when assisted suicide is morally safe, can this be

*“They avoided what might be considered the ‘real’ issue, the issue of the morality of assisted suicide”*

implemented in practice? The counter question becomes, if regulation is so difficult, is it preferable to rely on alternatives currently permitted?

### Chapter Six

"Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative" looks at how physicians, nurses, patients, families, and loved ones still can face clinically, ethically, morally, and legally challenging decisions throughout the dying process even when palliative care is effective. This chapter illustrates, with summaries of real clinical cases, how each of these practices might be a response to patients in particular clinical circumstances, keeping in focus the patients' values, as well as those of the families, other loved ones, and health care providers.

### Chapter Seven

"Responding to Legal Requests for Physician-Assisted Suicide" focuses on how physicians can respond to requests in an era of legalization. When legal physician-assisted suicide does become one of the many options to be freely considered for terminally ill patients with extreme suffering, some patients will view it as a right to expect on demand. The chapter considers the ethical implications of disclosing to patients assisted suicide as an option of last resort. When practicing in jurisdictions that permit assisted suicide, physicians should not encourage patients to hasten death. They remind physicians of the responsibility to focus on broader biopsychosocial concerns. This will require empathic listening and emotional support. This chapter also provides a context and vocabulary for physicians when responding to requests for assisted suicide.

### Chapter Eight

"Lesson from the Dying" describes the death of the author's twenty-six-year-old son who died as the result of carcinoma of the colon. The author reminds us that labor is the term applied when a woman is giving birth, and indeed it is a laborious process. The experience the father had with his son suggested that dying should also be termed labor, and he felt that his son had labored with considerable difficulty in the process of dying. The author poses the question: "What's wrong with assisted suicide?" He notes that terminal illness obviously involves the feelings and experience of others, but dying belongs to the patient and no one can do it for us. Suicide, however, directly affects others besides the person who has died in ways that can be uniquely damaging. Suicide is particularly damaging precisely because the death was self-inflicted. Those closest to the person who has committed suicide invariably feel particularly guilty. The author says that in addition to its professional, ethical, spiritual, and legal difficulties, assisted suicide therefore carries with it an added burden, one that is not often considered: a serious and lasting social and emotional price among the survivors.

I believe the Consensus Panel was well composed and the papers resulting from its deliberations are scholarly, readable, and focused on the questions addressed in an objective manner. The editors believe the papers will advance the policy dialogue and assist those who will be dealing with these issues in practice. I would add that for some dealing with these issues the questions will focus thinking and practices at the bedside, which should have the potential to cause physicians to alter their approach to management in a more compassionate manner. For example, Tulsky, Clampa, and Rosen make a clear statement that physicians are ethically obligated to explore in a meaningful way a request for assisted suicide. This includes discussion of what is permitted under the law if the patient persists. Although in no way obligated to accede to a request that violates the physician's moral code, he or she must avoid dismissal out of hand.

I find no evidence to suggest the editors or the panel members attempted to provide support for or against physician-assisted suicide.

Attention to these questions during clinical training may have a very positive impact on patient management, and opportunities for dialogue should be created during training. I do believe including discussion of the moral issue related to physician-assisted suicide would have been interesting and where the panel

"came down" on that issue would have been of some value. However, it is evident that what appears moral in this decade may not be so clear in the next. We cannot address the moral issue today and assure our conclusion will be the same when reviewed a decade hence.

Frank Davidoff, MD, the author whose son died from carcinoma of the colon, recalls that when he was a resident his chief of medicine kept reminding the residents that if a patient signed out of the hospital against advice, it was really the resident's problem. If a patient had to ask for barbiturates, the resident had not been doing his job. Dr Davidoff points out that today assisted suicide is no longer taboo and that we cannot be shocked or surprised when some doctors agree to assist the rare patient with ending life. Public discussion has provided the opportunity to understand the extent to which assisted suicide may violate the physician's deepest professional codes.

Dr Davidoff, however, cautions that the lessons learned leave us with "an unresolved, and irresolvable, tension." In my view, that's exactly where we should be. The only real tragedy would be if we were to become comfortable with the choices we face in caring for patients whose illness has made the work of living—and dying—intolerable.

This book will assist physicians in meeting their responsibility to learn all the lessons that will make us uncomfortable when we are confronted with a patient wanting "out against advice." It has the potential to assure that this generation of physicians and those following will understand and accept death as a part of life. If so, patients dying in pain will be a problem of the past and we may not fear patients seeking the good death.

*"Attention to these questions during clinical training may have a very positive impact on patient management, and opportunities for dialogue should be created during training"*

#### *Assisted Suicide: Finding Common Ground and Guidance for Real-World Implementation*

Lois Snyder, JD, and Arthur L. Caplan, PhD, eds

Indiana University Press, Bloomington and Indianapolis, 2002

232 pages, \$35 (hardback)

[Includes: annotated bibliography on assisted suicide; Oregon

Death with Dignity Act;

texts of 1997 U. S. Supreme Court decisions on *Washington et al.*

*V. Glucksberg*

and on *Vacco, Attorney General of New York, et al V Quill et al.*]



# NORTH CAROLINA MEDICAL BOARD

## Board Orders/Consent Orders/Other Board Actions

### November - December 2003 — January 2004

## DEFINITIONS

### **Annulment:**

Retrospective and prospective cancellation of the authorization to practice.

### **Conditions:**

A term used for this report to indicate restrictions or requirements placed on the licensee/licensee.

### **Consent Order:**

An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

### **Denial:**

Final decision denying an application for practice authorization or a motion/request for reconsider-

ation/modification of a previous Board action.

### **NA:**

Information not available.

### **NCPHP:**

North Carolina Physicians Health Program.

### **RTL:**

Resident Training License.

### **Revocation:**

Cancellation of the authorization to practice.

### **Summary Suspension:**

Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

### **Suspension:**

Temporary withdrawal of the authorization to practice.

### **Temporary/Dated License:**

License to practice medicine for a specific period of time. Often accompanied by conditions contained in a Consent Order. May be issued as an element of a Board or Consent Order or subsequent to the expiration of a previously issued temporary license.

### **Voluntary Dismissal:**

Board action dismissing a contested case.

### **Voluntary Surrender:**

The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

### ANNULMENTS

NONE

### REVOCATIONS

#### **BANERJEE, Haradhan, MD**

Location: Cleveland, OH  
 DOB: 4/03/1935  
 License #: 0000-22674  
 Specialty: FP/IM (as reported by physician)  
 Medical Ed: Nilratan Sircar, India (1957)  
 Cause: Conviction of a felony in State of Ohio v. Haradhan Banerjee, case number 384747.  
 Action: 12/09/2003. Entry of Revocation issued: Dr Banerjee's license is revoked by operation of law as of 10/08/2003.

#### **FINNEY, Patrick Curtis, MD**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 10/25/1969  
 License #: 0098-00247  
 Specialty: IM (as reported by physician)  
 Medical Ed: University of Tennessee, Memphis (1996)  
 Cause: Conviction of a felony in McCracken Circuit Court, Commonwealth of Kentucky, on 9/14/2000.  
 Action: 12/17/2003. Entry of Revocation issued: Dr Finney's license is revoked by operation of law as of 12/17/2003.

#### **NELSON, David Stephen, MD**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 12/16/1935  
 License #: 0000-13186  
 Specialty: EM/GS (as reported by physician)  
 Medical Ed: Bowman Gray School of Medicine (1961)  
 Cause: Conviction of a felony in U.S. v. David S. Nelson, case number 1:01CR319-1.  
 Action: 12/9/2003. Entry of Revocation issued: Dr Nelson's license is revoked by operation of law as of 11/26/2003.

#### **PULIVARTHI, Venkataramanaiah, MD**

Location: Gastonia, NC (Gaston Co)  
 DOB: 5/30/1960  
 License #: 0096-00114  
 Specialty: IM (as reported by physician)  
 Medical Ed: Guntur Medical College, India (1983)

Cause: Conviction of a felony in U.S. v. Venkata R. Pulivarthi, case number 4:02-673.

Action: 12/18/2003. Entry of Revocation issued: Dr Pulivarthi's license is revoked by operation of law as of 7/11/2003.

#### **TAYLOR, Carolyn Rose, MD**

Location: Clinton, NC (Sampson Co)  
 DOB: 1/18/1948  
 License #: 0000-24876  
 Specialty: GP (as reported by physician)  
 Medical Ed: New Jersey College of Medicine (1976)  
 Cause: In January 2003, Dr Taylor was convicted in Onslow County Superior Court of felony Uttering a Forged Instrument.  
 Action: 11/04/2003. Dr Taylor's North Carolina medical license is revoked.

### SUSPENSIONS

See Consent Orders:

**GALYON, Ronald Curtis, MD**  
**LESZCZYNSKI, Donald Brian, MD**  
**LOCK, George Joseph, Physician Assistant**  
**MILES, Martha Cope, MD**  
**TAUB, Harry Evan, MD**  
**THOMPSON, Jill Ellen, MD**  
**TUCKER, Peter Loren, MD**  
**WHITE, Steven William, Physician Assistant**

### SUMMARY SUSPENSIONS

#### **LUTZ, Robert Paul, MD**

Location: Chapel Hill, NC (Orange Co)  
 DOB: 5/05/1948  
 License #: 0000-27387  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1982)  
 Cause: Dr Lutz may be unable to practice medicine with reasonable skill and safety to patients as shown by the Notice of Charges and Allegations filed by the Board October 24, 2003 [see entry for this physician on the Board's Web site at [www.ncmed-board.org](http://www.ncmed-board.org)].  
 Action: 10/24/2003. Order of Summary Suspension of License issued: Dr Lutz's medical license is suspended effective 12/17/2003.

CONSENT ORDERS**BUZZANELL, Charles Anton, MD**

Location: Asheville, NC (Buncombe Co)  
 DOB: 9/23/1956  
 License #: 0098-00481  
 Specialty: AN/APM (as reported by physician)  
 Medical Ed: Georgetown University School of Medicine (1984)  
 Cause: To amend the Consent Order of September 2003 that reissued Dr Buzzanell's medical license, which he surrendered on 11/01/2002. In September 2002, Patient A, who has a physician-patient relationship with Dr Buzzanell presented to the ER at Pardee Hospital in Hendersonville with suicidal ideations. Dr Buzzanell authorized the ER physician to admit Patient A, but later failed to remember, and denied, he had authorized admission of Patient A. He prescribed his memory loss to his failure to take his prescribed medication. Patient B, who had a patient-physician relationship with Dr Buzzanell, had a history of lung cancer and, in September 2002, Dr Buzzanell performed an intrathecal pump revision on Patient B at Pardee Hospital. Patient B died the following day, leading to a conversation between Dr Buzzanell and the medical examiner, Dr Rholl. Dr Rholl believed Dr Buzzanell was less than forthcoming in discussing Patient B's surgery and said she would have ordered an autopsy had she obtained information she now believes she has regarding the surgery. Dr Buzzanell surrendered his license on 11/01/2002. He has now successfully completed evaluation and treatment at Ridgeview Institute for attention-deficit/hyperactivity disorder NOS and has continued his treatment on an outpatient basis. He has a contract with the NCPHP and the NCPHP reports he is compliant.

Action: 1/10/2004. Consent Order executed: Dr Buzzanell's license is reissued to expire on the date shown on the license; he shall limit his practice to no more than 40 hours a week; he shall restrict privileges to one local hospital; he shall not implant intrathecal pumps or spinal column stimulators and tunneled catheter systems; he shall continue his treatment with his health care providers, therapists, and support groups; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

**DAVIS, Tracy Denise, Physician Assistant**

Location: Durham, NC (Durham Co)  
 DOB: 5/22/1973  
 License #: 0001-03924  
 PA Education: Medical College of Georgia (2000)  
 Cause: On application for a PA license. In August 2003, Ms Davis informed the Board on her application that she had practiced as a PA in Georgia from November 2000 through August 2003 without being licensed. On learning she was not properly licensed, she quit her job, but she never informed her employer she had practiced without a license.

Action: 11/05/2003. Consent Order executed: Ms Davis is issued a PA license and is reprimanded; must comply with other conditions.

**DONDIEGO, Richard Michael, MD**

Location: High Point, NC (Guilford Co)  
 DOB: 1/15/1955  
 License #: 0095-01225  
 Specialty: IM/C (as reported by physician)  
 Medical Ed: Universidad Central del Caribe School of Medicine, Puerto Rico (1981)

Cause: On the request of Dr DonDiego for reinstatement of his license. Dr DonDiego failed to register his license by the required date in 2003 and, therefore, his license was placed on inactive status in May 2003. He now appreciates the importance of registering his license annually in a timely manner.

Action: 11/03/2003. Consent Order executed: Dr DonDiego's license is reinstated effective on the date of the Consent Order and is to expire on the date shown on the license [5/03/2004]; he shall submit documentation of his CME to the Board on an annual basis, beginning on or before 9/01/2004; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

**GALYON, Ronald Curtis, MD**

Location: Ellijay, GA  
 DOB: 8/12/1953  
 License #: 2003-01531  
 Specialty: ORS (as reported by physician)  
 Medical Ed: Eastern Virginia Medical School (1986)  
 Cause: On application for a North Carolina license. In 1992, Dr Galyon was diagnosed with alcohol abuse. In 1998, he tested positive for alcohol when reporting for work at a hospital in Georgia and was terminated from his employment at the hospital. In that same year, he was diagnosed with alcohol dependence. In June 1999, he entered into a Consent Order with the Georgia Board restricting his Georgia medical license as a result of substance abuse. In August 1999, he admitted to the Georgia Board that he had consumed alcohol and had been charged with DUI. He voluntarily entered substance abuse treatment in that same month. In October 1999, he entered into another Consent Order with the Georgia Board suspending his license. In August 2001, the Georgia Board issued a public Consent Order lifting Dr Galyon's suspension and reinstating his Georgia license subject to terms and conditions. In June 2003, he submitted a license application to the North Carolina Medical Board and disclosed his Georgia public Consent Order. The North Carolina Board requested he be assessed by the NCPHP. The NCPHP found Dr Galyon suffers from alcohol dependence and depressive disorder, but that he can practice safely under certain conditions and limitations paralleling those in his Georgia Consent Order. Dr Galyon admits his situation and the importance of proper treatment.

Action: 12/18/2003. Consent Order executed: Dr Galyon is issued a license to practice medicine and surgery; that license is immediately suspended; suspension is stayed on specific terms and conditions; he shall provide the Board a copy of his continuing aftercare contract and he shall abide by all the terms of that contract; he shall designate an acceptable supervising physician who will supervise his work and an acceptable treating physician with whom he will continue therapy; he shall provide a copy of this Consent Order to both physicians; the supervising and monitoring physicians will be in communication with each other and will report to the Board quarterly; they will immediately report any change in Dr Galyon's condition; Dr Galyon shall use triplicate prescription forms for all controlled substances he prescribes, with copies coming to the Board; he shall make a copy of his dispensing record available to the Board on request; he shall keep for the Board's inspection a prescribing/dispensing log for all controlled substances; unless lawfully prescribed for him by someone else, he shall not possess or use mind- or mood-altering substances or alcohol; he shall notify the Board within 10 days of such use and shall include the name of the prescriber and the pharmacy filling the prescription; he shall supply bodily tissue and/or fluid samples at the Board's request for testing to determine if he has consumed any of the substances cited; he shall maintain and abide by a contract with the NCPHP; he shall regularly attend AA and/or Caduceus meetings; must comply with other conditions.

**HSIEH, Stephen Szu-heng, MD**

Location: Lexington, NC (Davidson Co)  
 DOB: 9/09/1968  
 License #: 0097-00075  
 Specialty: IM (as reported by physician)  
 Medical Ed: Bowman Gray School of Medicine (1995)  
 Cause: On the Notice of Charges and Allegations filed 8/07/2003. In January 2003, the Medical Staff Executive Committee of Lexington Memorial Hospital concluded Dr Hsieh had committed unethical and inappropriate medical acts in reading EKGs and telemetry of other physicians' patients without a consultation order and billing for those services. The Committee recommended his clinical privileges be revoked. Dr Hsieh requested a hearing on this matter. As a result of that hearing and the explanation of the misunderstandings that led to the problem, the Committee stated it could not conclude that Dr Hsieh had any intent to mislead or defraud any patient or third-party payor. It also concluded Dr Hsieh had done all he could to rectify his mistakes by refunding the moneys he had received from his billings to patients and third-party payors. The Committee also noted his regret and remorse and concluded he was not likely to again make the mistakes that had led to this situation. As a result of the hearing, the Committee's

recommendation was modified and a formal reprimand was issued to Dr Hsieh. His privileges were suspended for 30 days and he was placed on probation for a year. He was also required to do at least 50 hours of community service, which he has completed.

Action: 11/20/2003. Consent Order executed: Dr Hsieh is reprimanded.

#### **JOHNSON, Maxwell Kenneth, MD**

Location: Sisseton, SD

DOB: 4/22/1939

License #: 0000-28226

Specialty: IM/ID (as reported by physician)

Medical Ed: University Otago, New Zealand (1965)

Cause: On the request of Dr Johnson for reinstatement of his license. In July 2001, Dr Johnson was reprimanded and fined by the Michigan Board of Medicine for failing to obtain adequate CME as required by Michigan law. In 2002, Dr Johnson failed to register his North Carolina license as required by North Carolina law and his license was placed on inactive status on 1/03/2003. He now appreciates the importance of registering his North Carolina license annually in a timely manner.

Action: 11/12/2003. Consent Order executed: Dr Johnson's license is reinstated effective the date of the Consent Order; he shall obtain CME as required by North Carolina law and shall document his CME to the Board beginning on or before 9/01/2004; must comply with other conditions.

#### **KLING, Timothy George, MD**

Location: Nags Head, NC (Dare Co)

DOB: 4/08/1944

License #: 0096-00591

Specialty: OBG (as reported by physician)

Medical Ed: University of Iowa (1971)

Cause: Dr Kling was reprimanded under a Consent Order issued by the Illinois Board in 2003 and he was ordered to complete 30 hours of Category I CME in fetal emergencies. This action was based on information that Dr Kling allegedly failed to perform a timely caesarian section, resulting in injuries to a newborn infant.

Action: 1/22/2004. Consent Order executed: Dr Kling is reprimanded; he shall comply in all respects with the Illinois Consent Order; must comply with other conditions.

#### **LEMAIRE, Pierre-Arnaud Paul, MD**

Location: Wilson, NC (Wilson Co)

DOB: 3/24/1960

License #: 0000-39440

Specialty: GS/VS (as reported by physician)

Medical Ed: University of Medicine and Dentistry of New Jersey R.W. Johnson Medical School (1985)

Cause: On the request of Dr Lemaire for reissuance of his license. In February 2002, Dr Lemaire was referred by his wife to the NCPHP for alcohol problems. He met with the staff of the NCPHP and admitted he was an alcoholic. He signed a contract with the NCPHP and agreed to enter a 28-day inpatient treatment program. He had also tested positive for cannabinoids. However, Dr Lemaire did not enter the treatment program because he was under subpoena in a malpractice case. The NCPHP agreed for him to undergo outpatient treatment, which he began promptly. In May 2002, he tested positive on drug screens and agreed to undergo assessment by a substance addiction treatment center. He was diagnosed with alcohol dependence and cannabis abuse. Residential treatment was recommended and it was recommended he not return to practice until he successfully completed the treatment program. In consultation with the NCPHP, he was given several options regarding his future. In July 2002, Dr Lemaire decided to surrender his license and did so on July 12. On 9/14/2002, the Board preferred Charges and Allegations against him related to his being unable to practice with reasonable skill and safety due to excessive use of alcohol and/or other substances. On 3/31/2003, Dr Lemaire and the Board entered into a Consent Order in which Dr Lemaire agreed to leave his license in a surrendered status until he could demonstrate his ability to practice with reasonable skill and safety unaffected by alcohol or other substances. He has now shown the Board he completed a 28-day inpatient addiction treatment program and attends four to six AA meetings a week and meets weekly with his AA

sponsor. He continues to work with and be monitored by the NCPHP, which reports he continues to show signs of recovery and asserts he is safe to return to practice with a temporary license under certain conditions. He admits to the Board that when he consumes alcohol or marijuana he is unable to practice medicine with reasonable skill and safety.

Action: 11/05/2003. Consent Order executed: Dr Lemaire is issued a license to expire on the date shown on the license [3/31/2004]; unless lawfully prescribed for him by someone other than himself, he shall refrain from use of all mind-or mood-altering substances and from alcohol; he shall notify the Board within 10 days of any such use and shall include in that notice the identity of the prescriber and the pharmacy filling the prescription; on the request of the Board, he shall supply bodily fluids or tissues for screening purposes; he shall maintain and abide by a contract with the NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by the NCPHP; prior to resuming practice, he must obtain practice site approval from the president of the Board; he agrees his practice, if allowed to resume, should be limited to Wilson, NC, and the adjoining area; must comply with other conditions.

#### **LESZCZYNSKI, Donald Brian, MD**

Location: Calabash, NC (Brunswick Co)

DOB: 4/14/1960

License #: 2001-00257

Specialty: IM (as reported by physician)

Medical Ed: Pennsylvania State University (1986)

Cause: Dr Leszczynski surrendered his license on 8/13/2001 after he was arrested and charged with obtaining a controlled substance by fraud in South Carolina. He was convicted on that charge in March 2002 and placed on two years probation.

Action: 1/22/2004. Consent Order executed: Dr Leszczynski's medical license is suspended indefinitely retroactive to 8/13/2001.

#### **LOCK, George Joseph, Physician Assistant**

Location: Princeton, NC (Johnston Co)

DOB: 8/26/1958

License #: 0001-01050

PA Education: Bowman Gray (1987)

Cause: In November 2000, Mr Lock signed a contract with the NCPHP in which he agreed to abstain from mood changing chemicals unless prescribed by his primary care physician or psychiatrist and approved by the NCPHP. However, Mr Lock did ingest such a chemical for shoulder pain without informing the NCPHP until asked for a urine sample. After being warned that he must completely abstain, within two weeks Mr Lock again used such a chemical for pain related to kidney stones without informing the NCPHP. When confronted, he admitted his action. In June 2002, he signed a Consent Order with the Board in which he agreed to abstain the use of mind-or mood-altering chemicals and alcohol unless lawfully prescribed by someone other than himself. He also agreed to supply bodily tissues or fluids to allow testing for such use. On April 24, 2003, he refused to provide a urine sample for testing. The next day, he supplied the sample to the NCPHP and it proved positive for codeine. In May, he provided another urine sample that proved positive for opiates. Mr Lock also admitted he forged his supervising physician's signature on a prescription for several Schedule III drugs. Mr Lock surrendered his PA license on May 20, 2003.

Action: 11/20/2003. Consent Order executed: Mr Lock's PA license is suspended indefinitely effective May 20, 2003.

#### **MILES, Martha Cope, MD**

Location: Sanford, NC (Lee Co)

DOB: 8/12/1953

License #: 0000-35989

Specialty: N (as reported by physician)

Medical Ed: University of Oklahoma (1988)

Cause: Relative to the Notice of Charges and Allegations of 9/17/2003. Dr Miles has not always kept accurate inventories of controlled substances she purchased for administration to patients in her office. On rare occasion, Dr Miles has left pre-signed prescriptions with her nurse so that, in Dr Miles' absence and after checking with her or her record of the patient's care, the nurse could reauthorize prescriptions. On one occasion, Dr Miles prescribed for her husband and daughter without keeping a record and without coordinating the pre-



scribing with their regular physicians. These actions constitute unprofessional conduct. Dr Miles has signed a contract with the NCPHP and the NCPHP reports she has complied with that contract.

**Action:** 1/15/2004. Consent Order executed: Dr Miles' license is suspended for 12 months; suspension is stayed immediately on conditions: she shall maintain and abide by a contract with the NCPHP; she shall successfully complete the Vanderbilt University Prescribing for Controlled Substances course, she shall continue treatment with a psychiatrist approved by the NCPHP and shall authorize that psychiatrist to share information about her with the Board, she shall continue in the care of the Duke or UNC pain centers, she shall practice no more than eight hours a day and no more than 30 hours a week, and she shall completely abstain from prescription medicine unless lawfully prescribed by her primary physician or psychiatrist and approved by the NCPHP; must comply with other conditions.

**RODINE, Mary Kim, MD**

**Location:** Weaverville, NC (Buncombe Co)  
**DOB:** 11/30/1954  
**License #:** 0000-27295  
**Specialty:** IM (as reported by physician)  
**Medical Ed:** University of Illinois (1980)  
**Cause:** On the request of Dr Rodine for reinstatement of her license.

On 9/04/1991, Florida granted Dr Rodine a license pursuant to an Order that stated the license was contingent on her entering into a contract with the Physician's Recovery Network based on her history of psychiatric treatment for depression. On 1/15/1997, Illinois placed her license on indefinite probation for a minimum of five years, suspended her controlled substance registration, and ordered she attend meetings of AA or NA at least three times a week and undergo random urine screens at least once a month. Dr Rodine failed to register her North Carolina license in 1986 and her license was placed on inactive status as a result. In October 2003, she asked that her North Carolina license be reinstated. She now appreciates the importance of registering her license in a timely manner.

**Action:** 11/14/2003. Consent Order executed: Dr Rodine's license is reinstated effective 11/14/2003; she shall maintain and abide by a contract with the NCPHP; she shall obtain required CME; must comply with other conditions.

**TAUB, Harry Evan, MD**

**Location:** Chapel Hill, NC (Orange Co)  
**DOB:** 11/24/1970  
**License #:** Resident Training License  
**Specialty:** P (as reported by physician)  
**Medical Ed:** Dartmouth Medical School (2001)  
**Cause:** Relative to the Notice of Charges and Allegations of 9/10/2003. After issuance of his RTL, Dr Taub became addicted to controlled substances legitimately prescribed for his wife.

In April 2003, Durham County Sheriff's Department officers and agents from the DEA searched Dr Taub's residence after obtaining information from a pharmacist that Dr Taub had obtained controlled substances under a false name. During the search of his residence, Dr Taub admitted to the officers and agents that he had been writing prescriptions for himself for about a year. As a result of his candid admission, formal charges were delayed pending Dr Taub's hospitalization for addiction. When he was released from treatment, he contacted Durham law enforcement authorities and accepted service of one felony count. On July 17, 2003, he was arrested and charged. In September, Dr Taub entered into a deferral agreement in Durham County District Court that placed him on supervised probation. The Court agreed that if he followed his treatment plan and submitted to drug testing for a year, charges would be dismissed and his record expunged. The NCPHP advocates for Dr Taub.

**Action:** 1/22/2004. Consent Order executed: Dr Taub's medical license is suspended indefinitely; such suspension is stayed subject to conditions and terms stated in the Consent Order; Dr Taub shall abide by all laws and rules; he shall maintain and abide by a five-year contract with the NCPHP; at the Board's request, he shall supply bodily fluids and tissues for drug testing; he shall give a copy of the Consent Order to all current and prospective employers; unless lawfully prescribed for him by someone else, he shall refrain from the use or possession of mind- or mood-altering substances and all controlled substances; he shall notify the Board within 10 days of his use of

such medication and shall identify the prescribing physician and the pharmacy filling the prescription; must comply with other conditions.

**THOMPSON, Jill Ellen, MD**

**Location:** Gastonia, NC (Gaston Co)  
**DOB:** 3/31/1957  
**License #:** 0093-00608  
**Specialty:** R/RNR (as reported by physician)  
**Medical Ed:** University of North Carolina School of Medicine (1991)  
**Cause:** On inappropriate prescribing of medications. From April through June 2002, Dr Thompson wrote prescription refills to a close relative for hydrocodone and other medications without keeping a medical record. In June and July 2002, Dr Thompson wrote prescriptions to another family member for hydrocodone and other medications without examining him or keeping a medical record. Several other instances of similarly inappropriate prescribing for relatives and friends occurred in 2002. These prescriptions were all written outside the scope of Dr Thompson's practice as a diagnostic radiologist. The foregoing constitutes unprofessional conduct.

**Action:** 1/22/2004. Consent Order executed: Dr Thompson's license is suspended for 60 days, which suspension is immediately stayed. Dr Thompson agrees not to prescribe to family members or others with whom she has a close personal relationship and shall not prescribe outside the scope of her medical practice.

**TUCKER, Peter Loren, MD**

**Location:** Charlotte, NC (Mecklenburg Co)  
**DOB:** 4/07/1955  
**License #:** 0000-31213  
**Specialty:** PS (as reported by physician)  
**Medical Ed:** Bowman Gray School of Medicine (1981)  
**Cause:** Relating to Charges and Allegations filed against Dr Tucker on May 1, 2003. During an in-office face lift and related procedures performed on Patient A by Dr Tucker, anesthesia services were provided by an independent contractor, a certified registered nurse anesthetist. The patient was observed by Dr Tucker and his staff to be awake and alert in the recovery room, and her care was assumed by the nurse anesthetist. While in the recovery room, the patient received an injection of fentanyl citrate IV from the nurse anesthetist without authorization from Dr Tucker. The administration of fentanyl caused the patient to suffer respiratory depression and arrest and required resuscitative measures. Initially, the nurse anesthetist attempted to deal with the situation on her own and without consulting Dr Tucker, declining offers of assistance from other staff members. Dr Tucker then resuscitated the patient and accompanied her to the hospital. The nurse anesthetist did not go to the hospital. The nurse anesthetist was grossly negligent in her failure to alert Dr Tucker to the patient's condition and, given the facts and circumstances of the patient's care, in giving the patient the fentanyl injection in the recovery room. Though Dr Tucker is responsible for the supervision of his staff, including his nurse anesthetist, he is not required to foresee or anticipate all acts of gross negligence, nor is he responsible for those acts. The nurse anesthetist was practicing outside her scope of practice and performing medical acts without supervision by a licensed physician. Three days later, the patient died from the effects of the fentanyl injection. Dr Tucker's care of the patient fell below the standards of medical practice in that he failed to supervise the nurse anesthetist sufficiently and that he should have discovered that his nurse anesthetist was practicing medicine in the recovery room without physician supervision. Dr Tucker ended the work relationship he had with the nurse anesthetist and implemented policies to supervise his remaining nurse anesthetists with more scrutiny to prevent similar incidents. Since these events, Dr Tucker has not experienced any problems with patient care involving anesthesia or post-operative recovery and he has fully cooperated with the Board.

**Action:** 11/20/2003. Consent Order executed: Dr Tucker's license is suspended for 12 months. Suspension is stayed subject to the following terms: he shall abide by all laws, rules, and regulations; he shall supervise his nurse anesthetists more closely and shall submit the relevant procedures and protocols to the Board, along with a random selection of patient charts, for review by the Board at times requested by the Board; and he shall meet with the Board or members of the Board as requested.

**WHITE, Steven William, Physician Assistant**

Location: Cameron, NC (Moore Co)

DOB: 12/19/1962

License #: 0001-02116

PA Education: Midwestern University (1996)

Cause: Mr White was the only licensed medical care provider on site at the Spout Springs Medical Center from June 2001 to December 2, 2002 under the supervision of Linda M. Robinson, MD. At that point, Mr White took a leave from practice due to illness. He recommenced practice under the supervision of Robert L. Ferguson, MD, on March 20, 2003. On May 25, 2003, Dr Ferguson notified the Board and Mr White that he would no longer serve as Mr White's supervisor. However, in the hope he would contract with another supervising physician, Mr White kept the clinic personnel in place and hired part-time physicians to care for patients through mid-June 2003. After May 25, when his approval to practice had lapsed, Mr White continued to treat patients at least four times and did lab work, drew blood, and wrote prescriptions backdated to before May 25. The Board performed a review of Mr White's practice and found problems relating to disposal of hazardous waste, maintenance of medical records, supervision, and physician support of practice activities. On June 19, 2003, Mr White closed the clinic and voluntarily surrendered his PA license. He has now taken and passed the PA National Recertifying Examination and he recognizes that, despite the conduct of others, PAs have an individual obligation to ensure timely compliance with Board rules.

Action: 12/03/2003. Consent Order executed: Mr White's PA license is suspended indefinitely effective June 19, 2003; such suspension is stayed effective December 18, 2003, subject to certain conditions and he is issued a temporary license to expire on the date shown on the license [6/30/2004]; he shall abide by all laws, rules, and regulations related to medical practice; he shall provide a copy of this Consent Order to all current and prospective employers; when he returns to practice, he shall practice with a supervising physician on site no less than three days a week; he shall maintain appropriate medical records countersigned by his supervisor; he shall cooperate with the Board's Investigative Department in monitoring his practice; must comply with other conditions.

**WODECKI, Tadeusz Kazimierz, MD**

Location: Stone Mountain, GA

DOB: 3/04/1954

License #: 2003-01312

Specialty: IM/GP (as reported by physician)

Medical Ed: Silesian Academy of Medicine, Zabrze, Poland (1979)

Cause: On Dr Wodecki's application for a medical license. In March 1999, the Georgia Board entered into a Consent Order with Dr Wodecki by which his license was suspended for 45 days and placed on probation for three years following suspension. Restrictions were placed on his authority to prescribe controlled substances. In June 1999, the New York Board charged Dr Wodecki with professional misconduct by reason of the action taken by the Georgia Board. He surrendered his New York license in October 1999.

Action: 11/25/2003. Consent Order executed: Dr Wodecki is reprimanded; he is issued a license to expire on the date shown on the license [6/04/2004]; must inform the Board of any change in residence or practice address within 10 days of the change.

**MISCELLANEOUS ACTIONS**

NONE

**DENIALS OF RECONSIDERATION/MODIFICATION****AMIR, Guy J., MD**

Location: Royal Palm Beach, FL

DOB: 6/24/1971

License #: NA

Specialty: NA

Medical Ed: Fatima, Philippines (1997)

Cause: In July 2003, the Board voted to deny Dr Amir's request to withdraw his application for a license and to deny his application for a license. At a hearing on 11/20/2003, the Board again considered the issues at Dr Amir's request. It found that substantial evidence exists to support the Board's denial of Dr Amir's application for a license based on his failure to provide

the Board evaluations of his postgraduate training within a reasonable time and in a reasonable manner.

Action: 1/13/2004. Findings of Fact, Conclusions of Law, and Order issued: the Board's previous denial of Dr Amir's application for a medical license was proper and shall remain in effect.

**DENIALS OF LICENSE/APPROVAL****DEBNAM, George Clyde, MD**

Location: Raleigh, NC (Wake Co)

DOB: 11/05/1927

License #: 0000-8749

Specialty: FP/OBG (as reported by physician)

Medical Ed: Meharry Medical College (1951)

Cause: Dr Debnam failed to satisfy the Board of his qualifications for a license.

Action: 1/06/2004. Letter issued denying Dr Debnam's application for a medical license.

**SURRENDERS****BARBER, Robert Anthony, DO**

Location: Morehead City, NC (Carteret Co)

DOB: 9/30/1954

License #: 2003-00222

Specialty: FP (as reported by physician)

Medical Ed: University of Health Sciences College of Osteopathic Medicine (1989)

Action: 12/22/2003. Voluntary surrender of medical license.

**BRANSFORD, Paris, MD**

Location: Houston, TX

DOB: 1/01/1930

License #: 0000-14435

Specialty: [not indicated]

Medical Ed: Meharry Medical College (1963)

Action: 12/16/2003. Voluntary surrender of medical license.

**GILLILAND, Corey William, DO**

Location: Ft. Bragg, NC (Cumberland Co)

DOB: 5/02/1967

License #: 2000-01486

Specialty: GP/AM (as reported by physician)

Medical Ed: University of Health Sciences College of Osteopathic Medicine, Kansas City (1999)

Action: 11/26/2003. Voluntary surrender of medical license.

**GRODER, Martin Gary, MD**

Location: Chapel Hill, NC (Orange Co)

DOB: 11/15/1939

License #: 0000-18262

Specialty: P (as reported by physician)

Medical Ed: Columbia University (1964)

Action: 1/28/2004. Voluntary surrender of medical license.

**PABST, Mark Dell, MD**

Location: Dunn, NC (Harnett Co)

DOB: 6/01/1936

License #: 0000-27835

Specialty: PD (as reported by physician)

Medical Ed: University of Iowa (1962)

Action: 11/24/2003. Voluntary surrender of medical license.

**ROWE, Theodore Charles, III, MD**

Location: Pilot Mountain, NC (Surry Co)

DOB: 9/30/1942

License #: 0000-16300

Specialty: FP/PH (as reported by physician)

Medical Ed: Medical College of Virginia (1968)

Action: 12/15/2003. Voluntary surrender of medical license.

**TYLER, Brent Joseph, MD**

Location: Durham, NC (Durham Co)

DOB: 10/01/1975

License #: RTL

Specialty: AN (as reported by physician)

Medical Ed: University of Illinois College of Medicine (2003)

Action: 1/15/2004. Voluntary surrender of resident training license.

COURT APPEALS/STAYS

NONE

CONSENT ORDERS LIFTED**NEWTON, Jimmie Isaac, MD**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 11/29/1938  
 License #: 0000-14269  
 Specialty: OBG (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1964)  
 Action: 11/04/2003. Order issued lifting Consent Order of 2/19/2003.

**SHAFTNER, Kimberly K., MD**

Location: Princeton, NC (Johnston Co)  
 DOB: 12/09/1954  
 License #: 0000-25426  
 Specialty: FP/ABS (as reported by physician)  
 Medical Ed: Ohio State University (1980)  
 Action: 1/06/2004. Order issued lifting Consent Order of 10/04/2000.

TEMPORARY/DATED LICENSES:ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**BUZZANELL, Charles Anton, MD**

Location: Asheville, NC (Buncombe Co)  
 DOB: 9/23/1956  
 License #: 0098-00481  
 Specialty: AN/APM (as reported by physician)  
 Medical Ed: Georgetown University School of Medicine (1984)  
 Action: 12/18/2003. Temporary/dated license extended to expire 6/30/2004.

**CONNINE, Tad Robert, MD**

Location: Hopkville, GA  
 DOB: 1/19/1964  
 License #: 0099-00193  
 Specialty: RO (as reported by physician)  
 Medical Ed: University of Southern Florida (1992)  
 Action: 12/18/2003. Temporary/dated license extended to expire 12/31/2004.

**GOTTSCHALK, Bernard Joseph, MD**

Location: Wilmington, NC (New Hanover Co)  
 DOB: 5/10/1955  
 License #: 0000-30162  
 Specialty: IM/ON (as reported by physician)  
 Medical Ed: University of Pittsburgh (1981)  
 Action: 1/22/2004. Temporary/dated license extended to expire 7/31/2004.

**GUALTEROS, Oscar Mauricio, MD**

Location: Aberdeen, NC (Moore Co)  
 DOB: 5/11/1964  
 License #: 0099-00236  
 Specialty: IM (as reported by physician)  
 Medical Ed: University of Navarra, Spain (1991)  
 Action: 1/22/2004. Temporary/dated license extended to expire 1/31/2005.

**KEEVER, Richard Alan, MD**

Location: Greensboro, NC (Guilford Co)  
 DOB: 6/11/1941  
 License #: 0000-16400  
 Specialty: OTO (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1969)  
 Action: 1/22/2004. Temporary/dated license extended to expire 1/31/2005.

**LAVINE, Gary Harold, MD**

Location: Winterville, NC (Pitt Co)  
 DOB: 11/04/1964  
 License #: 2001-00403  
 Specialty: EM (as reported by physician)  
 Medical Ed: University of South Alabama (1989)  
 Action: 12/18/2003. Temporary/dated license extended to expire 6/30/2004.

**MASSENBURG, O'Laf Sorento, Physician Assistant**

Location: Winston-Salem, NC (Forsyth Co)  
 DOB: 2/10/1960  
 License #: 0001-01117  
 PA Education: Bowman Gray (1988)  
 Action: 1/22/2004. Full and unrestricted PA license issued.

**MATTHEWS, Charles Joseph, MD**

Location: Raleigh, NC (Wake Co)  
 DOB: 2/03/1955  
 License #: 0000-27245  
 Specialty: N (as reported by physician)  
 Medical Ed: University of Virginia (1978)  
 Action: 12/18/2003. Temporary/dated license extended to expire 6/30/2004.

**PRESSLY, Margaret Rose, MD**

Location: Boone, NC (Watauga Co)  
 DOB: 5/05/1956  
 License #: 0000-34548  
 Specialty: FP (as reported by physician)  
 Medical Ed: University of North Carolina School of Medicine (1990)  
 Action: 12/18/2003. Temporary/dated license extended to expire 6/30/2004.

**SHAFTNER, Kimberly K., MD**

Location: Princeton, NC (Johnston Co)  
 DOB: 12/09/1954  
 License #: 0000-25426  
 Specialty: FP/ABS (as reported by physician)  
 Medical Ed: Ohio State University (1980)  
 Action: 12/18/2003. Full and unrestricted license reissued.

**SINGH, Prachee, Physician Assistant**

Location: Charlotte, NC (Mecklenburg Co)  
 DOB: 8/16/1976  
 License #: 0001-03694  
 PA Education: University of Texas, Pan American (2001)  
 Action: 12/18/2003. Temporary/dated license extended to expire 12/31/2004.

## See Consent Orders:

**BUZZANELL, Charles Anton, MD**  
**DONDIEGO, Richard Michael, MD**  
**LEMAIRE, Pierre-Arnaud Paul, MD**  
**WHITE, Steven William, Physician Assistant**  
**WODECKI, Tadeusz Kazimierz, MD**

DISMISSALS

NONE



## CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board  
PO Box 20007, Raleigh, NC 27619

Please print or type.

Date: \_\_\_\_\_

Full Legal Name of Licensee: \_\_\_\_\_

Social Security #: \_\_\_\_\_ License/Approval #: \_\_\_\_\_

(Check preferred mailing address)

☐ Business: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

☐ Home: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

*The Board requests all licenses maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 60 days of a move.*

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## North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: May 19-21, 2004; June 16-17, 2004; July 21-23, 2004  
August 18-19, 2004; September 22-24, 2004

### Residents Please Note USMLE Information

#### United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at <http://www.ncmedboard.org/exam.htm>. If you have additional questions, please e-mail Kelli Singleton, GME/Examination Coordinator, at [kelli.singleton@ncmedboard.org](mailto:kelli.singleton@ncmedboard.org).

#### Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

North Carolina Medical Board  
1203 Front Street  
Raleigh, NC 27609